COASTAL ENDOSCOPY CENTER
175 Gunning River Road, Bldg A, Unit 4
Barnegat, New Jersey 08005
Tel: (609) 698-0700 Fax: (609) 698-0777

Patient Name:_____

Todays Date:_____

DISCLOSURE FORM

1. You have been scheduled for a procedure at Coastal Endoscopy Center on _____.

2. Your **ARRIVAL** time will be confirmed with you 2 days before your procedure by a nurse at Coastal Endoscopy Center. Please have a list of your medications available when you speak to the nurse. If you have not been contacted by 2:00 pm the day before your procedure please call the center.

3. You must have a ride home after the procedure. You may only take a taxi home if you have a responsible adult companion with you in the taxi. Plan on being at the center about 2 hours.

4. Make sure the DO/MD/Physician has a current phone number so that we may call you. Indicate if we are to call home or if we may call work. **A detailed message may be left at the following number(s):_____.**

5. **To whom may we give or obtain information_____.**
   We can only speak with the patient, unless an individual is specified above.

6. You may receive up to (4) bills for your treatment at our center: the physician, facility, anesthesia and laboratory services. Contact your insurance carrier prior to your procedure to ask if you may have any patient financial responsibility such as copayment, deductible or coinsurance.

7. Your physician will address stopping aspirin, ibuprofen, non-steroidal anti-inflammatory drugs and blood thinners during your office visit prior to your procedure.

8. If you have an advance directive you may bring it with you on the day of your procedure. An advance directive (living will) is a written statement of your instructions for health care in the event you become incapable of making a decision. A brochure from NJ Bioethics Commission is available regarding advance directives. You can contact the center for more information.

9. The physician who is performing your procedure may have a financial interest in this facility. You may, of course, seek treatment at a health care facility of your own choice.

   By signing this form, you acknowledge that you: (1) are receiving this notice prior to the date of your procedure (2) have been informed of the financial interests of your physician (3) voluntarily desire to have your procedure performed at this facility (4) have the right to enter into an advance directive (5) have the right to make informed decisions regarding your care.

Patient Signature Date